DDN
Drink and Drugs News

5 November 2007
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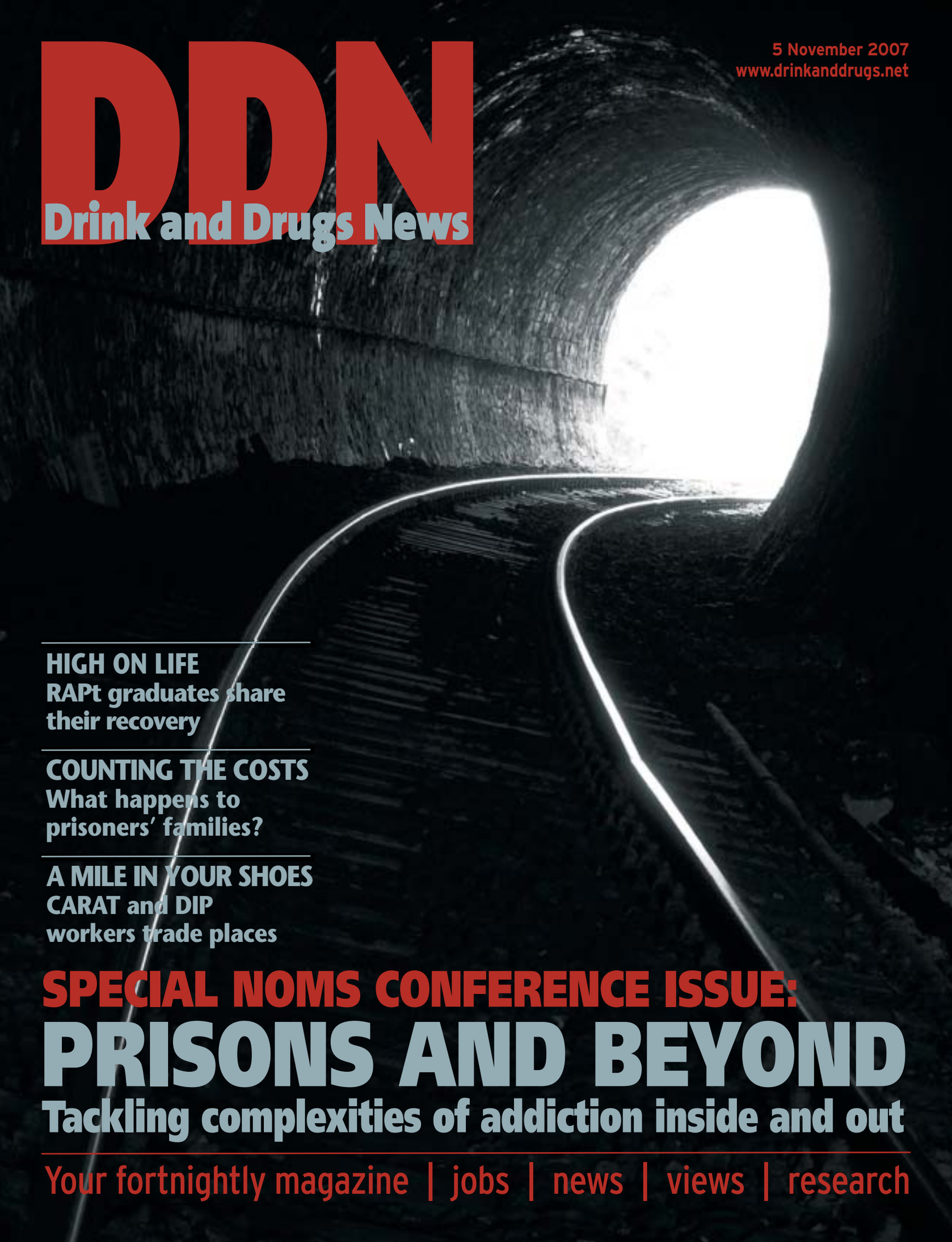

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What happens to prisoners' families?

A MILE IN YOUR SHOES
CARAT and DIP workers trade places

SPECIAL NOMS CONFERENCE ISSUE:

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Drink and Drugs News

5 November 2007

Editor's letter

It's strange being on the other side of the media. This week I took part in Radio Five Live's breakfast show, alongside Richard Phillips from Phoenix Futures, who was also in the London studio; and clients in treatment in Phoenix's centre in Hampshire, who were being interviewed throughout the morning by the programme's co-presenter.

I witnessed the very detailed research that went on before the programme, when the researcher contacted me to follow up different lines of enquiry and information sources. The reporter down in Hampshire heard stories of recovery first hand, and took account of the complexities of drug treatment in her reports.

What a shock then, when I had a look at the Five Live website later on in the day. Apart from a few valiant souls giving a perspective from the drugs field, the many comments represented a poisonous diatribe from members of the public. It was a stark reminder of why headline figures can be so dangerous – ready fodder for distortion. And of course headlines are impossible to retract and repackage to a public that is determined to make every drug user the reason for all society's ills.

The volume of responses from the field to the drug strategy consultation is a reminder of inspiration within the field as well as problems that need to be addressed. We shouldn't forget that, during the current media feeding frenzy.

In the centre of this issue we've featured the Prisons and Beyond conference, which looked at many different aspects of prison drug treatment. We hope you'll find it an interesting insight. It seemed appropriate to finish this issue with RAPt's reunion (page 18) – an enjoyable occasion that brings home the invaluable work of prison drug workers.

And finally... we're three years old this week! A massive thank-you for all your support – and to our advertisers for enabling us to keep a free circulation and vital editorial independence.

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Services fail drug prisoners

Prisoners with mental health needs, including those with substance misuse problems, are being failed by prison services, according to a new report from HM Inspectorate of Prisons.

The mental health of prisoners analysed the screening procedures of more than 250 new prisoners disclosing substance misuse problems on arrival at 14 prisons, and found that half were not given a urine test or referred to drugs services, and a third did not have a full history taken.

The report offers little evidence of effective joined-up working between substance misuse and mental health services in prisons, despite 'the well-established connection between substance misuse and mental illness'. Four out of five mental health in-reach teams felt unable to adequately respond to the range of need, and the report found no clear blueprint for delivering mental healthcare in prisons. Neither substance misuse nor mental health services were sufficiently alert to the different needs of BME communities, it says.

Prisoners also commented that detoxification was 'too little, too fast and too late,' and that little psycho-social or mental health support was offered to those withdrawing from drugs. Levels of alcohol dependency were not reliably assessed, and very few were offered alcohol detoxification. There was also evidence that continuity of care was disrupted on transfer.

'Much activity around the current national drug strategy has centred on breaking the cycle of drugs and crime, with drug treatment for offenders stated as a major focus point,' said DrugScope chief executive Martin Barnes. 'Yet time and again we are seeing failings in the duty of care for those prisoners with a drug or alcohol dependency, let alone the construction of a systematic, comprehensive prison drug treatment system.

'It is extremely concerning that only half of those who disclosed a substance misuse problem on entry to prison received a urine test and that only half were referred to drug services,' he said. 'It is clear that short, sharp detoxification is still the experience for many entering prison, even those who were in receipt of a prescribed substitute drug such as methadone prior to custody.'

The mental health of prisoners – a thematic review of the care and support of prisoners with mental health needs available at http://inspectorates.homeoffice.gov.uk/hmiprisons/thematic-reports1/Mental_Health.pdf?view=Binary

For full reports of the National Offender Management Service's Prisons and Beyond conference, see this issue, pages 9-16.

NTA hits out at BBC for 'misleading' story

The National Treatment Agency (NTA) has written to national newspapers that repeated a BBC news story claiming that public money is being wasted on unsuccessful drug treatment services to refute the allegation.

BBC reporter Mark Easton claimed that just 70 more people successfully completed their treatment drug free in 2006/07 than the previous year, despite an extra £130m in funding – equivalent to £1.8m per person. The letter, signed by chief executive Paul Hayes who took part in a tense interview with Mr Easton on BBC Radio 4's *Today* programme (*DDN*, 22 October issue, page 4), also stresses the importance of not focusing on drug free completions as the only benefit of treatment.

The letter states that the BBC misinterpreted figures on the NTA website and failed to check its facts before broadcasting the story. 'Sadly, the BBC got its numbers wrong,' it says. 'More than 5,800 individuals completed treatment free of illicit drugs in 2006/07, 2,200 more than 2004/05, not the 70 claimed by the BBC.' The error, along with the original story's exclusive emphasis on drug free completions 'misleads the public into believing that what is actually a successful system is failing', says the letter.

'The £400m that the government invested in drug treatment last year has to be judged against 180,000 individuals whose treatment has protected them from early death, reduced their criminality and provided the opportunity to rebuild their lives in the future,' it continues. 'To judge treatment solely on the small numbers that finally leave the treatment system in a given year as the BBC has done is misleading and dangerous to the drug users, their families and society.'

Infection risk high among homeless

Homeless people who inject drugs are more likely to share needles and are more at risk of injection-related infections associated with poor hygiene, according to a new report from the Health Protection Agency.

Shooting up: infections among injecting drug users in the UK also found that injecting crack cocaine, and injecting into the groin, both associated with higher levels of infection and risk, had become more common.

The report revealed that almost 75 per cent of injecting drug users had been homeless at some point. One in four who reported being homeless in the last year said they had shared needles within the last month, compared with one in six of those who had not been homeless.

Almost half of injecting drug users are infected with hepatitis C and one in four have been exposed to hepatitis B. One in 75 is HIV positive, a figure that rises to one in 20 in London. Along with the dangers of exposure to blood-borne viruses, however, injecting drug users are also at risk of abscesses, bacterial infections like MRSA, and wound botulism.

'Injecting drug users who are also homeless are likely to find it harder to maintain hygienic infection practices as a result of having to inject in public places or having difficulty in storing injection equipment somewhere clean,' said the report's author Dr Fortune Ncube. 'Injecting drug users in this situation are more susceptible to contracting severe life-threatening infections, as are those who inject into the groin or inject crack cocaine.'

Full report available at www.hpa.org.uk/publications/PublicationDisplay.asp?PublicationID=105

Cocaine use up but other drugs stable

There has been a significant rise in the use of cocaine powder in the last decade, according to new figures released by the Home Office.

The biggest increase occurred between 1998 and 2000, while last year 375,000 young people are estimated to have used the drug. Overall illegal drug use in England and Wales, however, remained stable between 2005/06 and 2006/07, while use of cannabis has fallen across all groups since 2003/04, according to *Drug misuse declared: findings of the 2006/07 British Crime Survey*. Use of 'magic mushrooms' has fallen significantly, while figures relating to heroin use remain stable.

Overall illicit drug use by 16-59 year olds was at its lowest level since the BCS started measurement in 1996, largely as a result of declining cannabis use. Among the 16 to 24 age group, use of any drug had fallen from 31 per cent to 24 per cent, while use of Class A drugs remained stable. Some agencies have urged caution in interpreting the figures, however, since British Crime Survey statistics are compiled from voluntary household surveys and exclude sections of the population such as prisoners and homeless people whose rates of drug use are likely to be high.

'We are not complacent and know that there is still a lot of work to do in tackling drug misuse – especially cocaine,' said Home Office minister Vernon Coaker. 'Drug taking wreaks enormous damage on individuals, their families and our communities, and we are determined to continue our efforts and bring drug use down even further.'

'British Crime Survey figures suggest that overall drug use among the general population remained stable since last year, with an overall downward trend in the last ten years,' said chief executive of DrugScope, Martin Barnes. 'This is clearly encouraging news but we cannot be complacent. The continued use of cocaine powder, particularly among young people, is of concern. It is important that we stay focused on addressing the serious drug problems that users, families and the wider community still face.'

Action on Addiction's director of client services Kirby Gregory shows off advertising in a fleet of taxis to promote their Sharp Service's Self-help addiction recovery programme in Liverpool. The programme has helped 55 addicts and alcoholics to leave clean and sober over the past two years, says head of service Jacquie Johnston-Lynch. 'We are really seeing the results of such a highly intensive and specialist service coming to fruition,' she added. As well as raising the service's profile, the taxi scheme was launched to make its telephone number easily available to members of the public. The number is on the side of three taxis, as well as inside.

Concern over conflicting overdose advice

Concerns have been raised to *DDN* over apparently inconsistent and contradictory advice given to people who call the emergency services to report an overdose.

While the NTA recommends the person be put in the recovery position, call centre staff using the Advanced Medical Priority Dispatch System (AMDPS) are advising callers instead to keep the person on their back with their airway open.

AMDPS, an American system for information given out prior to hospital admission, is used by some ambulance trusts in the UK including in Wales and Scotland, and concerns have already been raised by Scottish ambulance drivers. The issue – an important one since most overdoses are witnessed – has now been raised with the Welsh Assembly and the NTA, and both organisations have promised to take it forward.

The apparent contradiction came to the attention of staff carrying out overdose training in Wales. 'Hostel workers who had called for an ambulance after someone had overdosed said they were told not to put them in the recovery position,' said Teepee Training managing director Trudi Petersen. 'I'd actually heard this from four people before I was concerned enough to start investigating – I thought maybe it was a Welsh thing, but it's been happening in England and Scotland as well.'

'It is vitally important that substance misusers and those around them are informed of how to respond,' she said 'Being able to do the right thing at the right time may save a life. If practitioners' advice to use the recovery position is contradicted when individuals contact emergency services, this may lead not only to confusion over what is 'right' or 'wrong' on that occasion but may also have a knock-on effect around substance misusers' confidence in other health messages.'

If you have information on, or experience of, conflicting overdose advice please write to our letters page.

Heavy cannabis use exacerbates problems of young

Heavy cannabis use can exacerbate existing social problems among vulnerable young people, according to a report from the Joseph Rowntree Foundation.

The impact of heavy cannabis use on young people found that daily cannabis use among vulnerable 16 to 25-year-olds was seen to worsen problems such as unemployment, low educational achievement and homelessness, while others in the same age range – such as those in further education – reported few adverse effects. The report drew on interviews with 100 young people who had been using cannabis – mainly 'skunk' – on a daily basis for the last six months, and explored their attitudes to their drug use and its effect on their lives. Professionals such as youth workers were also interviewed, and in the main viewed cannabis as less harmful than the young people themselves.

'Young people might not be aware of the extent to which cannabis use might exacerbate their existing social problems, and professionals who have had experience of cannabis users in the past may assume the effects are relatively harmless if they take young people's assessment of the impact of cannabis use in their lives at face value,' said author of the report Dr Margaret Melrose. 'More probing may be required.'

Report available at www.jrf.org.uk/bookshop/details.asp?pubID=926

News in Brief

Level playing field

A new guide to the recruitment process for managers in the substance misuse field has been produced by Sussex DAAT with funding from the Home Office. *Taking a competency approach to fair recruitment* aims to ensure a consistent approach across organisations and encourage best practice, providing a step-by-step guide to the recruitment and selection process. It describes how competencies including DANOS fit in, and contains downloadable tools. *Available at www.westsussexdaat.co.uk and the workforce section of http://drugs.homeoffice.gov.uk*

Seizures up

The number of drug seizures by HM Revenue and Customs in England and Wales was up 50 per cent to 161,113 in 2005, according to Home Office figures. Cannabis seizures were up by 47 per cent, Seizures of class A drugs were up 31 per cent overall (20 per cent for heroin and 51 per cent for cocaine) and seizures involving class B drugs were up by 7 per cent. *Seizures of drugs in England and Wales 2005 available at www.homeoffice.gov.uk/rds/pdfs07/hosb1707.pdf*

Needle needs

Distribution of equipment should form only part of a range of harm reduction initiatives that needle exchanges deliver – just one of the conclusions drawn by a team of service user representatives sponsored by NTA to attend the International Harm Reduction Association's conference in Warsaw earlier this year. The team also concluded that there is much room for improvement in drug treatment in prisons. *Nothing about us, without us available at www.nta.nhs.uk/publications/documents/nta_nothing_about_us_without_us_ihra2007.pdf*

Overdose awareness

A week of activities to raise awareness of the risk of overdose is being held by Cornwall DAAT and Cornwall Partnership Trust's Drug and Alcohol Team (CDAT). An advice card for A&E staff to give to those who survive overdoses is being launched, and other initiatives include overdose information provided by local pharmacists and overdose training provided by CDAT. 'Like most people, drug addicts don't believe that an overdose will happen to them,' said Julian Steele-Perkins of CDAT.

Radio 4 junkies

Two significant events in the UK drug field happened on 18 October this year. The second was a highly positive conference about day services, run by KCA, which gave the opportunity for a number of providers and researchers to demonstrate that, although this is a modality which needs considerable further work, there is strong evidence that it is of significant benefit to thousands of people with dependency related problems.

The first, and the one which has been the subject of much discussion since, was the Radio 4 *Today* programme's assault on the record of drug treatment over the life of the current drug strategy. Using the springboard of contingency management and sensationalising a report on the apparent presence of manipulated forms of it in current UK practice, the reporter went on to heap criticism on the perceived lack of success of treatment in England.

The contrast between these two events couldn't have been greater. For instance the reporter on the *Today* programme said that there was 'no evidence whatsoever' for the efficacy of structured day programmes. Less than two hours later at the conference I listened to Dr David Best explaining the research that demonstrates the opposite.

Like thousands of others, I have great pride in the leaps forward that we have made in drug treatment over the last ten years. A less selective view of the figures available shows a vastly increased number of people receiving a service and, even more significant, an improvement in retention and completion figures.

The problem seems to be that, when drug treatment is anything other than rehab for celebs, we haven't explained to the public what it is and what realistic expectations would be. In addition we haven't sufficiently tackled prejudices surrounding our client group. What better example of this than a reporter's use of the word 'junkies' on BBC Radio's flagship news programme.

We have to face some unpalatable facts. The new NICE guidelines on psychosocial interventions have taken many of us by surprise and we need to regroup to demonstrate the efficacy of some of the work that we do. We still do not have good data on the success of much treatment; the recently commenced collection of the Treatment Outcome Profile (TOP) is late but much better than never. Most worrying: we still do not have enough options for service users seeking treatment exits.

To suggest that we have not made progress, however, is plain daft. We can see increases in retention and increases in participation in treatment. Where there are gaps in the system, residential rehabilitation for example, providers continue to offer excellent and proven treatment to service users from all backgrounds. This progress receives little attention from the media, for whom pulling at the thread of pockets of bad practice is much more rewarding than examining the diverse tapestry that is UK drug treatment.

We can fully expect the new drug strategy to make changes in the way in which we deal with drug use in the UK. There is no risk, however, that the well-proven maxim 'treatment works' will not be as firmly reflected in the plans for the next ten years as it has been for the last.

Bill Puddicombe, chair of EATA (European Association for the Treatment of Addiction) and independent consultant.

Incompetent times

Some DDN readers may well have read the extensive coverage of 'safe' drinking limits that appeared in the *Times* of 20 October. This formed not only the front page headline, but also a feature on pages 6 and 7.

Those less familiar with the history of the safe drinking debate may well have been left with a completely false impression of how the current government guidelines on safe drinking were arrived at.

These were, not as the *Times* says, based on the Royal College of Physicians (RCP) 1987 report, they were based on the 'Interdepartmental Report on Sensible Drinking' published by the Department of Health in December 1995.

This report established the current 'official' government recommendations of daily limits of two to three units for women and three to four for men. These are now printed on the containers of most UK produced alcoholic drinks.

It is coincidental that the RCP report chose two units a day for women and three for men. I was a member of the working group that produced the DoH report and daily units were deliberately chosen in order to dissuade drinkers from saving up their units for a weekly binge.

It is true that the conclusions of the Royal College of Physicians (RCP) 1987 report were not scientifically based. This was one of the main reasons for the 1995 committee being formed.

In contrast, our report was extremely well researched. Over 150 submissions of written evidence from concerned parties were considered and several oral 'interrogations' of expert witnesses took place, one involving the great Sir Richard Doll himself.

The vast majority of the report's conclusions, including those linking 'moderate' drinking with reduced heart disease, remain fully valid and consistent with subsequent research. It is salutary that Dr Richard Smith has now admitted that the RCP limits 'were not based on any firm evidence'. It is unfortunate that certain members of the medical profession, and several others, continue to insist on using the old ill-researched limits of the 1987 RCP report.

Furthermore, it may be of interest that I wrote a letter to the *Times* informing them of the deficiencies in their reporting, but they chose not to publish it.

Dr Rob Tunbridge, independent alcohol & drug impairment consultant, Rayleigh, Essex

Treatment and recovery

Congratulations to the Addictions Working Group, for their exposure of the distortions by some agencies of the Tory proposed strategy on drug abuse and addiction (*DDN*, 22 October, page 9).

The reported views of those agencies were remarkably similar, differing only to the extent they sought to distort the well-researched empirical evidence contained in the report. It is also notable that none of the agencies whose views were sought or reported, have recovery writ large in their activities or objectives. In fact it would be reasonable to suggest that recovery is not part of their strategy.

While acknowledging that the article was 'a round-up of reactions to Breakthrough Britain' and given that the majority of treatment agencies periodically listed in *DDN* are recovery-focused and use 12-step facilitation, the absence of any counter-balancing views in the report is puzzling. It may be a case that there weren't any, but in the interests of balanced reporting, one assumes that they were sought.

On the subject of recovery, I must thank Professor David Clark and Lucie James for their hard-hitting, no nonsense letter regarding the *Today* programme. One would be hard-pressed to find an equal of the latter, in terms of rhetorical rubbish. What it did expose was that both Paul Hayes and Dawn Primarolo are unaware of what is going on in their own backyards – or that they are, but seek to deny it. One thing we can be sure of as Professor Clark and Lucie James clearly highlight, is that the amount of time devoted to effective counselling is abysmal.

The failure of the current drug strategy, insofar as recovery and rehabilitation is concerned, can be attributed to the inexplicable refusal to utilise the worldwide evidence of 'what works', again as highlighted by the excellent articles from Professor Clark, describing the principles of effective treatment, and recovery. Such wilful dismissal of authoritative research and evidence, combined with 'treatment' involving the ongoing administration of addictive drugs, even where the addicted has expressed a desire to become drug free, serves only to increase the severity of an individual's addiction.

Peter O'Loughlin,
The Eden Lodge Practice

No secret anymore

So the NDTMS data is flawed – 'NTA dodges fire to announce more clients in treatment' (*DDN*, 22 October, page 4). This comes as no surprise to those of us who have been in many a meeting where service providers have been encouraged to take a liberal interpretation of what constitutes retention in treatment, planned discharges and positive treatment outcomes.

The real shocker behind the headlines must surely be the impact that striving to meet these government targets is having on treatment.

I understand and support the need for the harm minimisation and criminal justice agenda, but they have taken undue precedence because they are seen to have the political impact that this government seems to need. Some Drug Intervention Programmes (DIP), in their endeavour to keep offenders engaged, are ignoring re-offending behaviour, failures to turn up, non-engagement in programmes and illicit drug use. There needs to be a more balanced and realistic approach to treatment.

It saddens me that we seem to have come to accept the lowest common

Obituary – Roger Duncan

Swansea Drugs Project, 25 next year, has been marking the sad news of the death of one of its founder members and its first director, Roger Duncan. Roger, aged 58, died peacefully on 14 October, after a short illness.

Roger Duncan was without doubt one of the most knowledgeable and experienced workers in the drugs and alcohol field in South Wales, and had made an immense contribution to the development of substance misuse services across the region.

Ifor Glyn, current manager of Swansea Drugs Project, said: 'The death of Roger leaves a massive gap in the substance misuse field in Wales and beyond. He was a unique individual, passionate and compassionate, who was vociferous in demanding better services for those affected by drugs and alcohol. His work touched upon and improved the lives of thousands of individuals and families over the years, and it was due to his commitment and passion that Swansea Drugs Project continues in its work of offering services to users and their families.'

Before coming to Wales, Roger had worked for several social care services in London, including Release, Blenheim Project and Riverpoint. He was then appointed the first director of Swansea Drugs Project, and oversaw its development from a small voluntary group to a professional organisation with more than 25 staff. His passion and main focus was always the care and treatment of those affected by substance misuse, and he would always challenge discrimination and prejudice, and stand up against any inequality.

Under his management, Swansea Drugs Project opened the first needle exchange in Wales in an attempt to reduce the spread of HIV/Aids, and less than five years ago he developed the first specialist service for young people in Wales. He was an innovative and creative individual who believed that drug users had the same rights to services and help as other members of the community.

Over the years Roger had gained the reputation as the 'drugs guru' in South Wales, with countless numbers of drugs workers, social workers, nurses and teachers being trained by him. Many of his pupils now work across the UK, and share his passion and vision in securing effective and professional services for drug and alcohol users.

Sally Ward, his former partner and co owner of their drugs training business, Abracadabra, said: 'Watching Roger train people working with drug users was such a privilege. Although we often repeated the many successful Abracadabra courses over and over again, it was always fresh and special and everyone learned so much from his encyclopaedic knowledge of pharmaceuticals, and compassionate ways of working with drug users.'

Ifor Glyn added: 'There are so many of us who owe Roger for the inspiration and direction he gave us, many of us who continue to work in the substance misuse field. We could not have hoped for a better mentor, and it was a privilege and honour to have been able to learn from him. In the true sense of the word, he was a great man.'

The Swansea Drugs Project, management committee, staff and service users extend their condolences, and deep appreciation and gratitude for his contribution to his daughter Alice, Sally and his many friends and colleagues.

Swansea Drugs Project

denominator for our sons, daughters, husbands, wives, mothers and fathers! In real terms, there has been a disinvestment in the abstinence models of treatment. Some Tier 2/3 services no longer even mention abstinence or residential treatment to clients anymore because they know there is no point – there is no budget!

Drug agencies have huge pressure to comply with targets that are unrealistic and often, in my opinion, not in the clients' best interest. This translates into keeping or placing people in treatment who clearly are not appropriate, which then negatively affects other people who are trying to be positive about their recovery. I believe this contributes (in part) to the atrocious statistic of only '6 per cent of people on a drug treatment programme emerge free of drugs'! However, I do know of a significant number of agencies that far outperform this statistic with clients emerging and remaining drug free.

We need to raise our expectations of ourselves, and not fail society by expecting and accepting the lowest common denominator for others. We must focus on what works: positive and motivational relationships with our clients; boundaries that are firm, fair and caring; goals that reflect where the client is and where they want to go; protection for the children and young people; access to good quality housing, education, training and work.

The strength of any agency is its vision, philosophy and values and it is through these that we need to challenge the government strategy and not compromise good clinical decision-making to achieve their targets. We need to stand up and be counted for what we believe in and support our managers and workers to do the same.

This is a fantastic opportunity to challenge the drug strategy and improve drug and alcohol treatment in the UK – let's embrace it!

Sean Corbett, director,
Ethos Charity Solutions Ltd

Professional conduct

Kevin Flemen's letter 'Alternative Charlatans' (*DDN*, 10 September, page 8) drew attention to gaps in the regulatory framework for drug and alcohol treatment.

We have already made clear that we share these concerns and I do not propose to go over the same ground again. However, I do want to address the related issue of how we behave when we have concerns about a particular individual or service, and how we respond to any criticism we might receive.

In his original letter, Kevin raised some specific issues about the New Ways Clinic. Antoni Wilk, a 'partner' at the clinic, responded initially by asking that we remove his letter from the *DDN* website and, we understand, threatening Kevin with legal action. He also posted an anonymous article on a website registered under his name entitled 'The truth about KFx and Kevin Fleman (*sic*)'.

The article included a number of comments and claims aimed directly at Kevin and his company, KFx, including:

'Kevin's refusal to embrace all treatments that help with addiction, some say, *demonstrates he is not interested in really helping drug users, only in preserving his position as a self-serving, self-perpetuating and completely useless bureaucrat and any treatments which actually help with addiction are seen as a threat to his job rather than an opportunity to help drug users*.'

If we have real concerns about an individual or organisation offering services to people with drug and alcohol problems, we surely have not only a right to draw attention to them but also an active duty to do so. There are limits here. We must stick to the facts, and refrain from personal attacks, but given the stakes involved we simply can not stand by and remain silent.

Of course, those on the receiving end of a colleague's criticism also have a right to respond if they feel that they have been targeted unfairly. But again there must be limits to any right to reply and personal attacks posted anonymously on the internet seem unlikely to further the interests of the clients to whom we are all ultimately responsible.

Simon Shepherd,
chief executive, FDAP

Editor's note: Antoni Wilk was offered a right to reply to Kevin Flemen's letter in these pages, but he declined to do so. Kevin's original letter can be found at www.drinkanddrugs.net/features/sept1007/letters.pdf

We welcome your letters

Please email letters to the editor, claire@cjwellings.com or post them to the DDN address on page 3. Letters may be edited for reasons of space or clarity – please limit length to 350 words.

After the war... some debate

Launching their 'Tools for the debate' booklet last week, Transform Drug Policy Foundation called for a halt to the traditional ideological clashes on drug policy and invited an evidence-based debate with its feet firmly in public health. **DDN** reports.

'Fear of supporting any law reform remains an obstacle to debate. We're aiming to reframe the debate and make a case for evidence-based alternatives,' said Steve Rolles, author of Transform's new booklet, *After the war on drugs: tools for the debate*.

Polarised arguments in the media weren't reflective of the debate he said. 'We want to take the drama out of it. We don't want these ideological clashes anymore – we want to return it to the rightful arena of public health.'

Tools for the debate examines and counters the case for prohibition. It aims to provide evidence-based arguments for those willing to challenge current drug policy and takes a level-headed approach to why a criminal justice led approach is not solving society's drug problems. It examines many of the questions and ideas that are used to block the idea of legal regulation of drugs and answers them with research and comment from diverse sources.

Importantly, the booklet makes the point that being pro-reform does not conflict with being anti-drugs, nor should it imply that challenging failed drug legislation equates to encouraging or approving of drug use – a point emphasised by Rolles at its launch:

Drug policy drafted in the 1940s was completely redundant, he said, 'yet it's fixed in stone like the ten commandments. The big point is, you can be anti-drug and still support reforms. Avoiding a drug lifestyle is perfectly compatible with law reform.'

Paul Flynn MP said at last week's launch that 'people are exhausted at confrontation'. He was optimistic that different sides of the argument were coming together and said 'I believe the war on drugs is coming to an end'.

But Danny Kushlick recalled the magnitude of the task in hand. 'Gordon Brown's announcement that drugs will never be decriminalised shows how much drug policy plays the role of political football,' he said. 'The government won't scrutinise policy because it's not ready for policy change.'

It was, he said 'a policy of mass deception accompanied by a lot of dodgy dossiers', supported by propaganda from people who wanted to maintain the status quo. 'This is a policy that kills,' he said. 'Prohibition kills and consigns millions to a life of misery and degradation throughout the world.'

Kushlick referred to 'green room syndrome', mentioned in the report – where those in politics and public life agree that prohibition of drugs is unsustainable, but change their stance as soon as they are in front of the media. He said it was absolutely crucial that those outside political circles contributed to debate, to strengthen it beyond the whim of politicians.

Transform were aware that launching the document to their supporters who agreed that prohibitionists were 'doing the bidding of drug barons and drug cartels' was one thing – but that taking it into the rocky territory of mainstream debate and media would be quite another. Steve Rolles acknowledged that 'various journalists are extraordinarily powerful and clearly strike terror into the heart of policymakers', and hoped the booklet would help towards redressing this imbalance: 'We need to give people the tools for robust arguments and arguments they can stand behind.'

'After the war on drugs: tools for the debate' is free to download from Transform's website at www.tdpf.org.uk

Post-its from Practice

Do as you would be done by

Is excluding people from treatment ever justified? asks Dr Chris Ford.

I went to the waiting room to collect my next patient Imran. He was expressing his gratitude to one of our wonderful receptionists for treating him so well. It was odd to think that he had only come to us six weeks before, having been discharged from a neighbouring borough's specialist service for aggressive behaviour. His offence was shouting at his key worker who had promised to advance his housing application and had forgotten, and rather than just apologise she had implied to Imran that it wasn't important. He had been in bed and breakfast for over two years and he felt that sorting his housing was a key part in his recovery, and it was even in his care plan! He also had moderately severe depression and was under the care of a psychiatrist.

The service had given him a two-week reduction script from his maintenance dose of 80mg of methadone mixture to zero. They had offered him no alternative for care and in fact advised him that he couldn't get treatment from his then GP, as the GP was part of the same treatment system and if you got banned from one service you got banned from all services. This doesn't happen in our borough but it is not the first time I have heard of this rule.

Fortunately, a friend of Imran's told him about the excellent Heroin Helpline, run by Release [1], who do amazing work offering advice and at getting people who have been excluded into treatment. A worker from Release rang and asked if we could offer immediate help as Imran's health had already deteriorated in the three weeks since losing his script. We agreed to see him that day. He arrived a few hours later looking unkempt, frightened and depressed. After an assessment, urine screening and examination he left with a prescription, a smile on his face and an appointment for the next day.

The new *Clinical Guidelines on Drug Misuse and Dependence*[2], which have just been issued, state very clearly that 'a decision to temporarily or permanently exclude a patient from a drug treatment service or provide coerced detoxification should not be taken lightly. Such a course of action can put the patient at an increased risk of overdose death, contracting a blood-borne virus or offending.' They also go on to state that if patients are excluded from a service, they should be offered treatment at another local service.

I feel Imran's service failed on both these points. I am not excusing his behaviour and he obviously needed to be talked to and boundaries set, but surely exclusion for reasonable frustration is both not acceptable and potentially dangerous to him?

In the six weeks since he has joined us he has been an exemplary patient, worked on his care plan and can begin bidding for properties next week. So, might his behaviour be something to do with the way he has been treated?

1. *Release www.release.org.uk – Heroin Helpline 0845 4500215*
2. *www.nta.nhs.uk – Updated: Drug Misuse and Dependence, UK Guidelines for Clinical Management*

Dr Chris Ford is a GP at Lonsdale Medical Centre and clinical lead for SMMGP

PRISONS AND BEYOND

The second annual NOMS conference focused on drug treatment services in custody and continuing care after release, and involved staff from all areas of criminal justice in two days of lively debate. **DDN** was there.

Back on track

Rob Wooley's experiences of his journey from prison to beyond illustrated how the chance of drug treatment put his life back on track.

Being able to go straight from prison into treatment is critical in preventing relapse, says Rob Wooley, an ex-drug user who now works at the Burton Addiction Centre. He was addressing delegates who worked in all areas of the prison system to give them a picture of his experiences as a service user. 'I was one of the lucky ones,' he said. 'If it wasn't for that I'd probably be back in prison, or dead.'

Describing his journey through the prison system he said he'd first gone into a young offenders' institute at 17 after becoming involved in football violence. 'Like everyone else I sat in prison thinking if I got parole I'd behave myself when I got out,' he said.

He first smoked cannabis in prison, and on coming out got a job, only to lose it after six weeks. By now he was smoking cannabis all the time and binge drinking – 'I used to end up in casualty'. Back in prison after getting involved in a violent argument, he was inside when drug testing was introduced. 'I saw it all change from cannabis to heroin overnight' he said, reflecting the scramble to escape detection from cannabis, which stays in the drug user's body for much longer than heroin.

On release he did odd jobs but felt institutionalised. 'I didn't feel I fitted in anywhere,' he said, eventually getting another six month sentence. This time he started smoking heroin. 'I got out, got a job and was doing well. But I was smoking cannabis all the time, drinking heavily, and using heroin and crack. I was quite arrogant – I thought I could use and knock it on the head when I wanted to.'

It wasn't long before he was addicted and lost his job. He started working for drug dealers, delivering heroin, and his consumption increased. 'I went on a methadone programme, but I nearly OD'd and my life was in a mess. I couldn't see a way out.' He started injecting a cocktail of drugs. 'If it went in a syringe, I'd use it,' he said. 'I knew that one way or another I was going to be dead.'

By now he was stealing from drug dealers and after robbing a taxi driver was caught and put on remand. 'I was glad I was caught,' he said. 'I needed help.' He was put into detox and was on suicide watch. He was given a four and a half year sentence, and was on therapeutic treatment for two and a half years, 'the hardest two and a half years I've ever done.' He started to learn about addiction issues and, on release, went straight into a 16-week programme.

'Not everyone is able to go straight into an addiction centre,' he said. 'I would have been back using if it wasn't for that.' He now works in the addiction field himself.

'I'm still in the early stages of recovery,' he says. 'None of this would have happened if it wasn't for the help I had in the system.' **DDN**

Significant progress – but plenty still to do

Progress in the Prison Service should not be underestimated, said Roger Howard, chief executive of the UK Drug Policy Commission (UKDPC) the body set up earlier this year to analyse objectively what's working in the drugs field.

It was a testimony to government and prison workers that so much had changed in such a short time, he said. 'More prisoners have access to the help they deserve.'

But there was plenty to tackle. While getting people into treatment had been shown to be beneficial to the individual, their family and the public, benefits to society were limited by those who remained untreated and still engaged in crime. Harm reduction successes such as reducing cases of HIV were counterbalanced by the failure to stall cases of hepatitis C. There was more information needed on why a disproportionate number of black people were incarcerated.

Other key areas demonstrated the need for more evidence, Mr Howard pointed out. There was no evidence that tougher enforcement made drugs less accessible, and there was little evidence that education had the effect of deterring drug use.

The UKDPC was keen to build on existing research, highlighting that one size treatment did not fit all, and would investigate the importance of offering therapeutic treatments as well as maintenance.

'The criminal justice system and drug treatment system are constrained by environmental factors, particularly housing and employment,' said Mr Howard. 'We need to look at pathways through treatment.' Reconviction rates among drug users were still unacceptably high.

'Despite the Prison Service's efforts, we still know little about evidence in the Prison Service on what works and what doesn't,' Mr Howard pointed out. Improving the knowledge base on treatment was critical to the future.

Prison service has to achieve even more with less

'We have a great deal to be proud of,' Sarah Mann, head of the interventions and substance abuse unit at NOMS, told delegates. 'We work with a very difficult group of people.'

But, she warned: 'Our work was supported by a huge injection of cash. Those days have ended.'

Tightening of belts would need to take place against a backdrop of growing challenges. The prison population was at an all time high, rising at a rate of 110 inmates a week, she pointed out. The probation caseload was growing by 7 per cent a year. The prison system was under assessment: the PriceWaterhouse Cooper review of drug treatment, which started in August, was focusing on service models right through the prison system, identifying changes that were needed and looking at quality and cost-effectiveness.

The focus on commissioning and best value for money needed to be balanced by joint-working to achieve continuity and consistency, according to Ms Mann. A review of 25,000 prisoners had shown that 'the criminal justice system really makes a difference', based on predicted and actual reconviction rates.

While the prison service was working to a tight timescale to feed experts' and academics' advice into the drug strategy (whose consultation ended the week after the conference), findings would be a vital influence on NOMS' strategic review of offender management.

Aftercare and service user involvement are core

Long-term structured aftercare and service user involvement are the core tenets of clinical guidelines regarding drug treatment in prisons, said director of quality at the NTA, Annette Dale-Perera.

The revised Drug misuse and dependence: guidelines on clinical management (known as the 'orange book'), published in September, was not just about doctors, but about anyone providing healthcare, she said. It was very evidence-based and dovetailed with the NICE suite of guidance, while user groups and carer groups had fed into it extensively.

NHS providers, whether PCTs or mental health trusts, had an obligation to ensure that all of their healthcare provision met with guidance standards and, while the orange book didn't have the same formal status as the NICE guidelines, it was used in General Medical Council investigations of a doctor's practice. 'So these aren't things that you can ignore,' she said. 'Guidelines are not rules, but the idea is that the vast majority of practice falls within the guidance. It helps to define clinical competence.'

While previous guidelines were prescribing- and opiate-focused, the new ones covered all treatments, all drugs and psychosocial interventions. They covered community, prison and inpatient residential care, she said, and were about clinicians being properly supervised and monitored. 'The key messages are that they advocate structured treatment and that healthcare and aftercare are paramount, as is service user involvement.'

'But there are also some 'don't dos", she stressed. These included ultra-rapid detoxification involving sedation, and providing treatment without adequate clinical governance. It was also essential not to ignore the dependent children of drug using parents, and make sure the risks they faced were properly assessed.

'Effective treatment involves a range of interventions, not just prescribing,' she said. 'Integrated care pathways are key.'

Evidence base is essential for action

It is necessary to move 'from faith to science' when tackling addiction issues in prison, director of the National Addiction Centre, Professor John Strang told delegates. 'It's one thing to hold beliefs about whether a particular approach is good or not, but it has to be based on evidence.'

Prison represented an 'extraordinary concentration' of people with addiction problems, he said, with heroin use rates standing at 40 per cent of the prison population, compared with one per cent of the general population. But prison also represented an extraordinary opportunity to carry out 'an MOT or stock take' on the health of prisoners.

Hepatitis B vaccination, for example, was a 'major health gain that could be achieved incredibly cheaply', and tests for cardiac function were also essential, particularly for those on methadone. On reception of all prisoners, NICE guidelines recommended competent detox, competent physical and psychiatric assessment and the initiation of continuing care.

Heroin constituted the major problem in prisons, he said, despite a big drop in amphetamine and cocaine use. 'There's more persistence of heroin problems in prison than for other drugs, and by a big margin,' he said. There were however significant developments around treatment, with lots of work being done around drugs for maintenance and to stunt relapse risk, along with interest in developing implantable drugs and abuse-resistant versions of drugs like methadone.

What happened on release was also key, he said. 'I'm sure there's a dangerous tendency to be preoccupied with what happens inside the establishment, but effective transfer is vital – we need to make sure the baton is not dropped, because the cost is too high.'

Joanne Edes-O'Connor of HMP/YOI Aylesbury collects the winner's trophy as Substance Misuse Worker of the Year. Judges were particularly impressed by her initiatives in developing workshops, designing an awareness package on steroids, arranging visits to the prison by stakeholders from county councils, and her work facilitating DIP appointments for clients. Runners-up were Emily Hewerdine of HMP/YOI Brinsford and Sarah Mills of HMP Exeter. Prison Substance Misuse Team of the Year was the CARAT team at HMP Wayland, with runners-up the substance misuse team at HMP Dorchester and the interventions team at HMP Altcouse.

Early Intervention key to health

Early intervention is the key to stabilising and safeguarding prisoners in the first stages of custody, according to Dave Marteau of Offender Health and Dave Sherwood of NDPDU.

In early custody, drug workers would be treating prisoners for withdrawal from alcohol, opiates, tranquilisers, nicotine and stimulants, said Mr Marteau, and it was essential to avoid the dangers that withdrawal brought with it, which could range from insomnia and agitation to psychosis, seizures and stroke.

The psychological effects of withdrawal could make the already distressing time of early custody even more difficult to deal with, he said. 'If you're not sleeping, things seem far worse, especially in the middle of the night. Couple that with pain and you've got a dangerous combination. It's important to remember that heroin's not just a very powerful anaesthetic, but an emotional anaesthetic as well.'

The first 28 days of custody were crucial for the Integrated Drug Treatment System (IDTS), he said, as risks to the prisoner during that period were substantial. Along with early intervention, what worked was effective monitoring – particularly of alcohol and stimulant withdrawal, stabilisation of opiate withdrawal, early psychosocial support and ensuring there was no rapid detoxification.

NOMS

'addressing prison concerns'

'The Prisons and Beyond conference is an opportunity to hear and act on delegates' concerns – and that is exactly what NOMS will do,' pledged Martin Lee, head of the prisons drug strategy team in NOMS' interventions and substance abuse unit. He added: 'We do listen but we can't always act immediately.'

Among the main needs identified from last year's conference were more resources to meet treatment demands, a basic standard of harm reduction to be delivered to everyone, needle exchanges in prisons, more effective partnership working, and meeting the diverse needs of all clients. There was also concern around a lack of crack cocaine-specific services, and that CARAT services were too target-driven, he said.

Since then there had been additional funding, he said, with an extra £18.5m for the Integrated Drug Treatment System in prisons (IDTS), alongside very close working with the Prime Minister's strategy unit. Another success factor was the very positive effect DIP inreach workers had had in prisons, and there was new guidance on dealing with persistent prolific offenders (PPOs). There were also new therapeutic community and rehab specifications, successful piloting of the alcohol befriending scheme in partnership with Alcohol Concern, the introduction of an alcohol information pack and video and the development of a crack cocaine treatment package with COCA.

Other initiatives had included publishing a revised version of *Prisons, drugs and you* with Adfam, holding treatment provider forums and the introduction of a families toolkit.

'Further significant developments' could be expected soon, he said. There was close work with the probation and DIP teams to develop guidance for those released on licence, development of a drug treatment demand model, the updating of the CARAT practice manual, and continued development of IDTS.

More crack cocaine training courses were being planned, he said, and a diversity toolkit and workforce strategy were also being developed, along with a DIP good practice guide and the introduction of disinfecting tablets for injecting drug users.

The system was highly complex, he acknowledged, and it was essential that processes didn't lose too many people along the way. There was also a mismatch in clients identified by different agencies, with cases not being closed.

Throughcare had to be improved, as 65 per cent of those leaving prison got 'nowhere near offender management or the probation service', and record keeping and communication needed urgent improvement. 'Procedures and processes need a very thorough look to decide whether they're fit for purpose,' he said, and emphasised that this would happen.

BME clients being failed by system

People from BME communities are over represented in the criminal justice system but under-represented in treatment, according to head of strategic development at The Federation, Abd Al-Rahman. 'For many people in BME communities, the experience of people from their communities as suspects, defendants and prisoners is real cause for concern,' he said. 'You'll find the same thing in the mental health system, and with school exclusions.'

There was a lot of pressure to develop partnerships and for BME-specific services to merge, but it was essential to find solutions to ingrained problems at a grass roots level. 'We need to address the culture of organisations,' he said, but acknowledged that the emotive nature of race issues could sometimes hinder debate. 'People can be frightened of being called a racist if they're white, or being accused of having a chip on their shoulder if they're black.'

It was also important to address issues of home and culture, he said, as extended black families often had a tendency to keep members away from treatment services because of the stigma: 'There can be a fear that people will be disowned by their family if they engage with DIP services, so often the prison environment is the first access to treatment they have.' Faith beliefs, particularly in the Asian community, could also prevent people from accessing services. 'It's a real concern that so many people are accessing treatment for the first time through prison,' he said.

The cost of keeping it in the family

Drug addicted prisoners leave shattered lives in their wake. What happens to the wrecked families when their relative is off the scene and in the arms of the law?

Shame, guilt, isolation, stigma and stress-related illness are some of the experiences family members are left with, when a relative goes into prison. Sometimes the experience affects them so badly that they unable to function at work or in education; sometimes they are worried by drugs or paraphernalia left at their house. In many cases they are facing financial hardship and enormous debts – including to their family member's drug dealer – and are left to cope with children who are themselves struggling to come to terms with the absence of their parent.

While compiling a report for the Home Office, published in August, Karen Whitehouse heard many family experiences of before and after arrest. Apart from the arrest itself being traumatic, many families had lived for some time under the terrifying reign of their addicted relative. As well as the mood swings and violence of their relative, they suffered their belongings being stolen, needles and paraphernalia being hidden around the house, and lived in dread of dealers or the police arriving in the night. Some reported waiting until their relative was asleep, then calling the police to come and arrest them – anything to change the situation and put their loved one in the path of some help.

The trauma usually lasts far beyond the drug user being removed to prison. One mother summed up her fear while talking to Whitehouse: 'Whatever I do now, I'm always wondering if the police will turn up. I can't take a long bath, sleep without clothes or even go to the loo in peace. I never relax anymore. The police have even turned up looking for my son when he's in prison. I'm a nervous wreck, I really am.'

Another described the moment of arrest: 'We were in bed when they came to arrest my boyfriend. My little girl was only three and she was in another room. I could hear her screaming but they wouldn't let me go to her. They had my boyfriend on the floor with his hands behind his back so they could put handcuffs on him. He was shouting. It was really scary. I don't think my little girl is over it yet 'cos she clings to me like mad.'

The purpose of the Home Office report, which ends in a consultation questionnaire, is to inform commissioners of how they can improve services for families locally, regionally and nationally. Some action points shine through the research, such as the arresting officers needing to show more sensitivity to families during arrest. Others will need resources so that family liaison workers can offer help with the immediate emergencies of child support, debt containment and feeling safe at home – as well as the longer term but no less crucial matter of preparing for their relative's release from prison. Too many families, it seems are living with the consequences of drug addiction without receiving any of the treatment.

Vivienne Evans, chief executive of the family support charity Adfam, says as well as needing support themselves, families are a neglected resource in achieving positive outcomes for their convicted relative.

'Families are a starting point for interventions,' she says. 'If you're a service provider, what you've got with a family is a readymade support service.' She stresses that investment in family support services will reap the benefits of improved outcomes: 'Providing practical, emotional and financial support means a much improved likelihood of retention and successful outcomes.' And as Evans points out, families' involvement offers the best chance of ensuring a seamless transition for prisoners from treatment to aftercare.

'Taking part... gives opportunity of a new outlook to many men who have been brought up in fractured families or in care. Many... were not in contact with their own fathers, or had a member of family in prison, and seemed doomed to repeat the cycle of family breakdown.'

Becoming a family man

Safe Ground's drama courses are giving fathers the skills to rebuild relationships with their families from within prison.

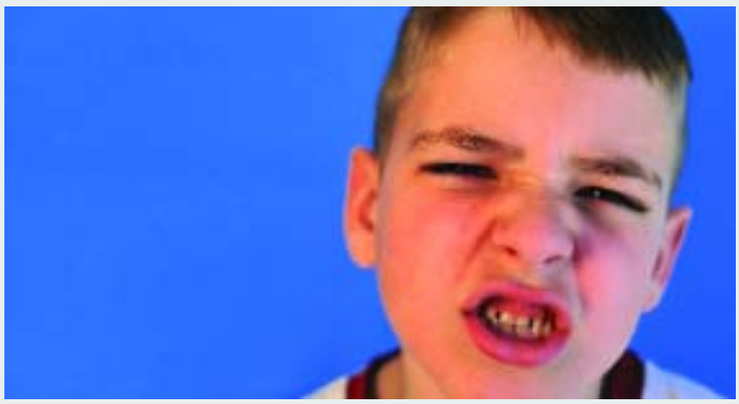
When a father goes into prison he can become mentally detached from his family, as well as being physically separated. Selfishness and hopelessness can set in, as the usual boundaries of the day don't matter any more – there's no shopping to fetch, no collecting the children from school, no bills to pay.

Hearing these experiences informs Antonia Rubenstein's work at Safe Ground, the training organisation that visits 23 prisons in the UK to deliver their Family Man or Fathers Inside courses. Using drama, discussion and role-play, the sessions encourage prisoners to look at their situation in relation to their families, and to plan an alternative life to re-offending.

Taking part in the group gives opportunity of a new outlook to many men who have been brought up in fractured families or in care. Many of the men, it was found, were not in contact with their own fathers, or had a member of family in prison, and seemed doomed to repeat the cycle of family breakdown.

Based on evidence that parenting education motivates fathers to keep their families together and find legal ways of supporting them, the courses have been developed with prisoners themselves, and are designed to explore difficult subjects in a supportive environment made up of their peers.

The drama levels a class of mixed educational ability and lets prisoners try out the skills needed to maintain family relationships from prison. Learning the skills of trust, problem-solving and taking responsibility for their actions can give them a flying start over their old way of life and bring their family back into the picture with real hope of change.



'Group work can be intimidating... clients feel powerless and you are between them and their drug of choice... By splitting the group in half, with one half acting the cravings and the other half resisting, you can see the different types of cravings that affect individuals and how hard they try to fight them.'

Taking on the schoolyard bully

Changing clients' drug habits can start with making them realise they have a choice and don't need to be bullied by cravings, as Chris Robin's training sessions demonstrate.

'Clients will often throw their hands ups and say they didn't have any choice: "I'm a crack head, of course I took it when he offered it to me".'

Chris Robin trains people to understand their clients and the thought processes that can hamper their progress in drug services. He teaches workers to help their own clients understand the cravings and triggers that lurk 'like schoolyard bullies, knowing when someone is vulnerable and when to strike'.

He tells clients what to look out for when doing one-to-one assessments, and the first rule is not to take any hostile reactions personally. 'Clients can see workers as the enemy because you are the person trying to stop them using drugs and keeping them away from the buzz,' he points out. Furthermore, clients are 'their own personal psychologists', experts on themselves, who will provide you with lots of information and seem to be prepared to make concessions – 'but in reality they are acting to protect the buzz'.

Group work can help to unravel the reason for chasing drugs. You can get clients to talk about what the buzz means to them personally, says Robin, and the group setting can help them realise that everyone has these feelings: 'Starting from when you were a baby or a small child you naturally enjoyed altered states of consciousness, such as getting dizzy on a roundabout.'

It's important to get the dynamic of group work right. He believes these sessions work best with two people leading, particularly if they have contrasting personalities. 'Group work can be intimidating... clients feel powerless and you are between them and their drug of choice,' he says. Group sessions can work particularly well when looking at cravings: 'By splitting the group in half, with one half acting the cravings and the other half resisting, you can see the different types of cravings that affect individuals and how hard they try to fight them.'

He cautions to proceed gently when getting clients out of their comfort zones, 'as drug workers are always told to do'. Wanting to stay in our comfort zones is human nature, he points out and 'clients need to be coaxed and cajoled out, not forced... they need to be reminded that humans might be creatures of habit, but these habits can be changed.'

Don't get angry, stay even

What do you do when confronted by a client acting the tough guy? Marjella Green has developed techniques for calming the situation.

Most people instinctively try to calm an aggressive person's behaviour by staying calm themselves, says Marjella Green, an expert in anger management.

Most of it's common sense and being aware of your body language and tone, she says. But there are other strategies you can learn to divert an outburst. Know the risks, says Green, and assess the space you're working in so you cannot be caught off-guard. At the most practical level, 'be aware of exits and be able to call for assistance'.

Looking for early signs of aggression can head off a confrontation. Often the body language gives away a client's intentions. An attentive professional can spot subtle changes in facial expression, says Green. They might begin to pace around, even before raising their voice.

'It's important to be aware of different cultures' use of facial expressions and attitudes to personal space, so as not to misinterpret signals', she points out.

Understanding the causes behind the aggression is an essential step to understanding what can trigger it. 'Often people's aggressive behaviour stems from not being understood or accepted, or it may be used as a barrier or persona – especially when they feel they cannot appear vulnerable, such as in prison.'

Green suggests taking a staged approach to managing a client's aggression. 'First you should allow them to pre-vent,' she says, splitting the word to signify venting the anger – letting it out and getting it off their chest to diffuse a situation. 'It also helps to recognise four main types of anger: lightning, as in quick to strike but soon over; tornado, that thrives off chaos; flood, that builds up slowly and surges over long periods; and a volcano, that's slow to erupt and slow to cool.'

Take control of yourself in an aggressive situation, set the tone and follow a structured approach, she advises. Ensure you are calm by taking deep breaths, relax your body language and repeat your coping strategies in your head. Then allow the person as much as control as possible, encouraging them to problem-solve.

'If this does not diffuse the situation you must take control,' says Green. 'Make them aware of options... it's up to you to restore order and set expectations for the future.'

Say it again

conference quotes

'We have done damage by doing the wrong work, with the wrong clients, at the wrong time.'
Chris Robin, trainer

'Most aggressive behaviour underlies not being accepted or understood.'
Marjella Green, consultant

'Assessment is the key. If you don't assess properly then nothing that follows makes sense.'
Graham Hickman, NDPDU

You have to assess quantity, because you have to count the beans, so you can get more money to buy more beans.
Delegate

'People can be frightened of being called a racist if they're white, or being accused of having a chip on their shoulder if they're black.'
Abd Al Rahman, The Federation

'All drug users should be offered vaccinations against hepatitis B and C, and we should be treating alcohol misuse and smoking as well.'
Annette Dale-Perera, NTA

'Seventy-five per cent of all in-prison injectors share equipment… It adds up to a nasty picture.'
Dave Marteau, Offender Health

'Steroids are not big on the public agenda because there's no link between steroid use and crime.'
Michael Bird, counsellor

'What you've got with a family is a ready made support service.'
Vivienne Evans, Adfam chief exec

'Effective transfer [from prison] is vital – we need to make sure the baton is not dropped, because the cost is too high.'
Prof John Strang, National Addiction Centre

'Alcohol users feel they come from a different world, so they retract and get bullied more.'
Delegate

'Like everyone else I sat in prison thinking if I got parole I'd behave myself when I got out.'
Rob Wooley, former prisoner and now drug worker

'Procedures and processes need a very thorough look to decide whether they're fit for purpose.'
Martin Lee, head of prisons drug strategy team, NOMS

When two worlds collide

Alcohol users should not be isolated from prison drug treatment, but helped proactively from the outset, says Stephan Dais – and prison drug workers all over the country who are frustrated by their 'hidden' clientele.

'The alcohol users in our prison feel like they've come from a different world, so they retract and get bullied more. Drug users are more streetwise,' says one prison drug worker, when asked to think about the difference between heroin, crack and alcohol users.

Through asking the questions, Stephan Dais, a CARAT manager at Pentonville Prison, gets to the heart of the problem for those who end up in prison as a consequence of their alcohol misuse. Being 'clumped together' with other drug users does not help alcohol clients to identify with the same problems and options for treatment.

Alcohol is socially acceptable – a situation constantly bolstered by advertising – a façade that mask the reality, which is that there are more alcohol users than drug users in prison.

Although RAPt are piloting a version of their drug treatment programme and are about to roll it out further, Dais's group of prison workers from all over the country report limited options for alcohol clients – visits from Alcoholics Anonymous, 'which don't always appeal to younger people who can find it difficult to respond to a semi-religious thing' and very limited group work on offer, because of the limited resources dedicated to alcohol treatment.

There's an oft-repeated scenario where prisoners are encouraged to 'play up' any slight drug problem, so they can get onto a programme that will help them with their alcohol dependency. Many of the group confirm this, and want to get 'the huge problem and issues' for prison alcohol users out in the open.

Dais thinks lack of ring-fenced funding for alcohol treatment should not be used as an obstacle against doing anything. 'Alcohol treatment can live easily under overall drug strategy,' he says.

Supporting against stigma

Most drug using sex workers avoid structured services altogether, so are often ill-equipped to deal with the traumas of court and prison. Community-based services like SHOC can offer empathic support.

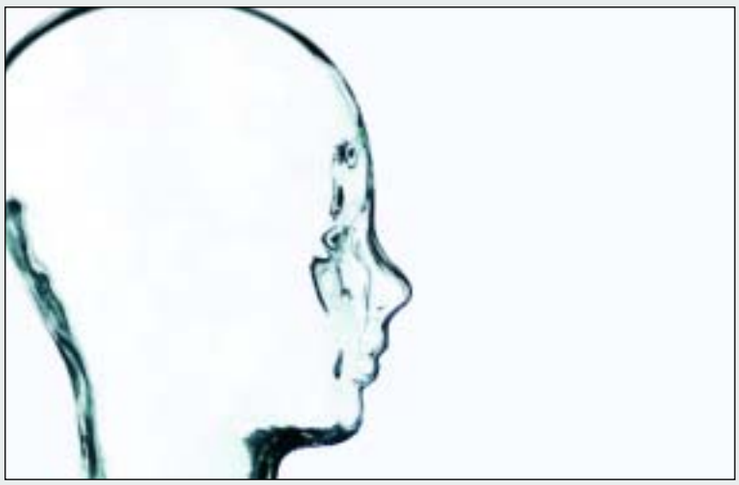
A survey carried out five years ago discovered that 90 per cent of drug using sex workers avoid treatment. They avoid contact with support services because they feel stigmatised or were unable to fit in with opening hours.

Little wonder then that few can escape the circle of courts, fines and prison. Looking at the two reasons for living this lifestyle – using drugs to perform sex work, or (more commonly) becoming a sex worker to fund a drug habit – often uncovers layers of other problems relating to low self-esteem and abuse from others.

Michelle Farley is service manager at SHOC – Sexual Health on Call. Her 13 years' knowledge of sex work, through both personal experience and working to help female sex workers has helped her network to best effect. Approaching her local London DATs, she explained the need for outreach services, flexible treatment and fast access to services, and negotiated an out-of-borough partnership so her team can beat the postcode lottery by working across boundaries.

'Our female staff team supports women in a very non-judgmental way,' says Farley. Importantly for their clients, they help with the legal issues that crop up – particularly challenging ASBOs and CRASBOs (Anti-Social Behaviour Orders made on conviction) from the courts. They also help clients to try and access treatment on arrest, as sex work is not currently a trigger offence.

SHOC's next challenge is to link their community successes with support for clients in prisons and custody which, with the exception of a few schemes such as 'MASH' (Manchester Action on Street Health) that operates in Styal Prison, seem to be all too rare.



'Working with dual diagnosis means always trying new and imaginative approaches, and there have been positive responses from clients to cardiovascular gym activities, auricular acupuncture and relaxation techniques.'

A fragile state of mind

Prisoners usually enter the custody suite in a highly stressed state. An alarmingly high number of new arrivals can't cope with their substance misuse and mental health issues and take their own lives. Leeds Prison's Nina Davis and Anne Cowan race to get to them first.

Dual diagnosis is astonishingly common among the prison population. A survey by the Office for National Statistics points out that one in five prisoners has had psychiatric treatment and many more reach their tipping point with the stress and anxiety of being incarcerated.

Anne Cowan is a drug and alcohol worker at Leeds Prison and Nina Davis works alongside her in the mental health team. They see people arrive at the safe custody unit with 'varying levels of vulnerability', and say this is the point at which they need to be proactive.

The risks of not doing so speak for themselves, they warn: 11 per cent of suicides happen within 24 hours of entering prison; 32 per cent happen within a week. Of those taking their own life, 62 per cent had a history of drug misuse.

Cowan and Davis have a mission of identifying signs of distress, so that prisoners can be given access to care and services in good time. They foster a supportive, structured, caring and safe regime within the prison and pay particular attention to alleviating stress and anxiety within the high-risk first week in prison.

To spot the danger signals in time, they are aware of needing to keep access routes to mental health services as open as possible, encouraging anyone in the prison to refer a prisoner in need. When meeting with individual clients, they are always on the lookout for those with priority need, and will then sign them onto the dual diagnosis programme without delay. Beyond this stage, they will be referred to mental health inreach teams, or whatever further support they need.

Working with dual diagnosis means always trying new and imaginative approaches, and there have been positive responses from clients to cardiovascular gym activities, auricular acupuncture and relaxation techniques.

With detoxing clients often displaying paranoia and hallucinations, it's not always clear if the symptoms are related to drugs or other mental disorder. But whatever the complexities of their difficult condition, the team feels confident that their prisoners with mental health are at least 'lucky to be in a place where everybody wants to help them'.

Beyond just sport

Steroid use is rocketing in the community, but little is being done to respond to its popularity in prison. Michael Bird argues that prison teams need to work in partnership to tackle its menace head on.

Aggressive prison culture does nothing to diminish peer pressure to act tough. For steroid users the macho environment can add to the reasons why they should not stop taking their drug of choice, says Michael Bird.

Although supply of steroids – which are a class C drug unless taken on prescription – can carry a 14-year prison sentence, steroid users don't consider themselves as drug addicts so are unlikely to access services, explains Bird, who has been a CARAT worker and outreach counsellor before training professionals including prison staff.

Finding steroid users to offer them treatment is difficult in the first place, he says, as routine drug tests are not carried out for steroids. Risks associated with the drug include aggression, depression and other mental health problems, high blood pressure and liver damage.

With one or two workers for a population of two or three hundred, where and how do you find time to address the issue, particularly when there's no solid client group in prison?

Assessing the scale of the problem in each prison would be a start, he says, in partnership with CARAT workers. Then awareness of steroid use needs to be raised with drug workers, so they can equip their clients to make informed choices about steroid use.

From not being recognised as a problem, steroid use could then be flagged up as a part of prison drug culture to be tackled seriously.

If I ruled the world

Chief executives of four voluntary sector providers started a debate on what's right and wrong with drug services.

Brian Arbery, Adapt:

'We've seen targets become an end in themselves.'

'Further treatment through more funding is the answer, not a postcode lottery.'

Ian Wardle, Lifeline:

'There is chronic short-termism. We are driven by short-term contracts.'

'The NTA is in a very difficult position. Part of the problem is that society approves of alcohol and disapproves of drugs.'

Karen Biggs, Phoenix Futures:

'Service providers and prison staff might have different cultures but we all need to work together for mutually beneficial ends.'

'Care pathways focus on community into prison and not very much the other way around.'

Mike Trace, RAPt:

'More long-term drug intervention programmes are needed, and they should to be organised in a strategic way. Let's have one person whose job it is to oversee all the services in their area.'

'What we should be reviewing is whether our services are any good.'

DDN conference reporting team: Claire Brown, David Gilliver and Ian Ralph.

Web reports recording all sessions at the NOMS conference, including workshops, will be available from 12 November at www.drinkanddrugsnews.com

A mile in your shoes...

When DIP worker Iain Evans was asked to take part in a job swap with a CARATS worker, he thought 'how hard can it be?' Two months in Vicky Jones' job changed his tune – and that of his job swap partner.

Talking about their experiences on the pilot, both participants felt it had shaken their preconceptions to the core. More to the point, it had given them an appreciation of how things work 'on the other side' and given them building blocks for more effective working practices and better co-ordination of care.

Back to day one, and Evans said he jumped at the idea: 'I thought what could be easier? All your clients are under one roof. I thought there'll just be a few forms to fill in, then a referral to DIP. The reality – nowhere to hold a confidential conversation and an avalanche of paperwork – soon began to hit home.

He was also stressed by clients' expectations. 'Not all clients are willing participants, but they think CARAT workers can perform miracles,' he said. 'They're not happy when you give them a form before you can do anything for them. They vent their frustration when their needs aren't met.'

Another eye-opener was the amount of drugs circulating within prison: 'I woke up to the fact when someone asked me for a second detox because they were using every day.'

CARAT worker Vicky Jones thought it would be easy on DIP, driving around visiting people who were expecting it. But it wasn't. 'I was looking for non-existent addresses, arranging appointments to find they were not in when I arrived. In two days I'd seen no clients!'

Her vision that her turn as a DIP worker would mean 'a couple of calls, and then the job would be done' descended, in reality, into a catalogue of frustrations. 'It was difficult to place people,' she said. 'One person was barred from every hostel and had an ASBO for the city centre where the treatment centres were. I got him sorted – but when I checked up a couple of weeks later, he hadn't been to a single appointment!'

She experienced the disorientation of deadlines that shifted without warning. 'I thought getting an EDR [Earliest Date of Release] meant there was plenty of time. But HDC [tagging], days back, early release and appeals can disrupt the whole timescale,' she found. 'I had to chase around trying to get someone a methadone script who about to be released.'

Jones also thought it would be plain sailing to get clients into services when they left prison, but was tripped up by waiting lists, uncertainty of whether or not they showed up – and if they did, whether they were still motivated to participate once they were outside.

So was the job swap a useful exercise, despite its frustrations? 'Yes, very valuable,' they both agreed. 'I'd advise anyone to do a job swap, I can now appreciate what CARATs face,' said Evans.

'Having now seen situations first hand, I can pass on information more accurately and with more confidence,' added Jones. 'I shared this with my team so they can gain from my experience – and I know I won't be so hasty to judge!'

Recovery and communities of recovery (part III)

Professor David Clark of WIRED looks at the definition and conceptual boundaries of 'addiction recovery'.

In my last Briefing, I pointed out that in the substance misuse field, the US was on the brink of shifting from a problem-focused interventions paradigm to a solution-focused recovery paradigm.

William White, author of *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*, points out that this focus on recovery is occurring at a time when there is no clear definition of recovery. This has resulted in much confusion in the field, with people using the term with different meanings, or even avoiding using the term.

There are various other consequences of having no clear definition of recovery. For example, how do we measure outcomes of addiction treatment? At present, we chose a somewhat randomly selected time period after treatment entry or discharge (eg six months) and ask whether the person is still using or drinking. Is this of value, particularly when we define addiction as a chronic relapsing condition?

White has recently published *Addiction recovery: Its definition and conceptual boundaries* in an effort to stimulate debate about the defining nature of recovery. This article is not easy to access, since it is written in an academic journal (*Journal of Substance Abuse Treatment*, 33: 229, 2007). However, many of the ideas are available at www.facesandvoicesofrecovery.org/pdf/White/2005-09_white_kurtz.pdf.

I briefly summarise the main points made in these articles. As I have emphasised earlier, it is essential that we in the UK gain a better understanding of recovery and how people resolve substance use problems. We are in great danger of focusing all our attention on treatment, for the sake of treatment itself, when treatment is only a tool to help people resolve their substance use problems.

Should recovery be applied to the resolution of only certain types of substance use problem?

Recovery is a medical term that connotes a return to health following trauma or illness. How the term is used in the substance misuse field is strongly dependent on an understanding of what one is recovering from. Obviously, there is no recovery if one has no condition from which to recover.

Substance use exists on a continuum from non-use and recreational use, through to periodic problematic use, and on to use that results in severe problems, generally linked to dependence and addiction. Someone who decides to stop using drugs after a period of recreational use, or after a short period of experiencing problems, cannot be said to have recovered. The terms 'quit' and 'cessation' are more appropriate terms.

'Is someone who has overcome heroin addiction, but still smoking cigarettes, in recovery?'

The term 'recovery' is best reserved for those people who have resolved or are trying to resolve serious substance use problems, in particular those that meet diagnostic criteria for addiction and dependence.

Does recovery from a substance use problem require a complete and enduring abstinence?

Recovery has often been defined as a state of sustained abstinence from a drug or category of drugs to which one previously met diagnostic criteria for dependence or addiction.

However, addiction researchers often talk about the resolution of substance use problems in more graded terms. For example, some people manage to drink in a non-problematic manner after a period of problematic drinking. This switch is particularly the case for people with mild-to-moderate drinking problems, but also occurs in a small proportion of people originally defined as being dependent.

This moderated resolution of drinking (and other substance use) problems appears to be more common among people with lower problem severity, lower rates of co-occurring psychiatric illness, and greater personal and family resources. Do we say that these people have not recovered, despite the fact that the resolution of their problems might be considered more normal if they have gone back to social drinking?

No doubt this issue will continue to generate a good deal of debate in the field. Some will argue that this group of people could not have had a problem to recover from in the first place, if they were able to return to normal drinking.

White argues that 'moderated recovery' might be best used as a description for those individuals with severe substance use problems who have achieved sustained deceleration of the frequency and intensity of substance use to sub-clinical levels.

In defining recovery, we need to be looking at life problems that accompany substance use and the actual substance use itself. What do we say of a person who reduces drug use – but is not abstinent – and resolves life problems that have accompanied his problematic use?

Does recovery require abstinence from, or a deceleration of, all substance use?

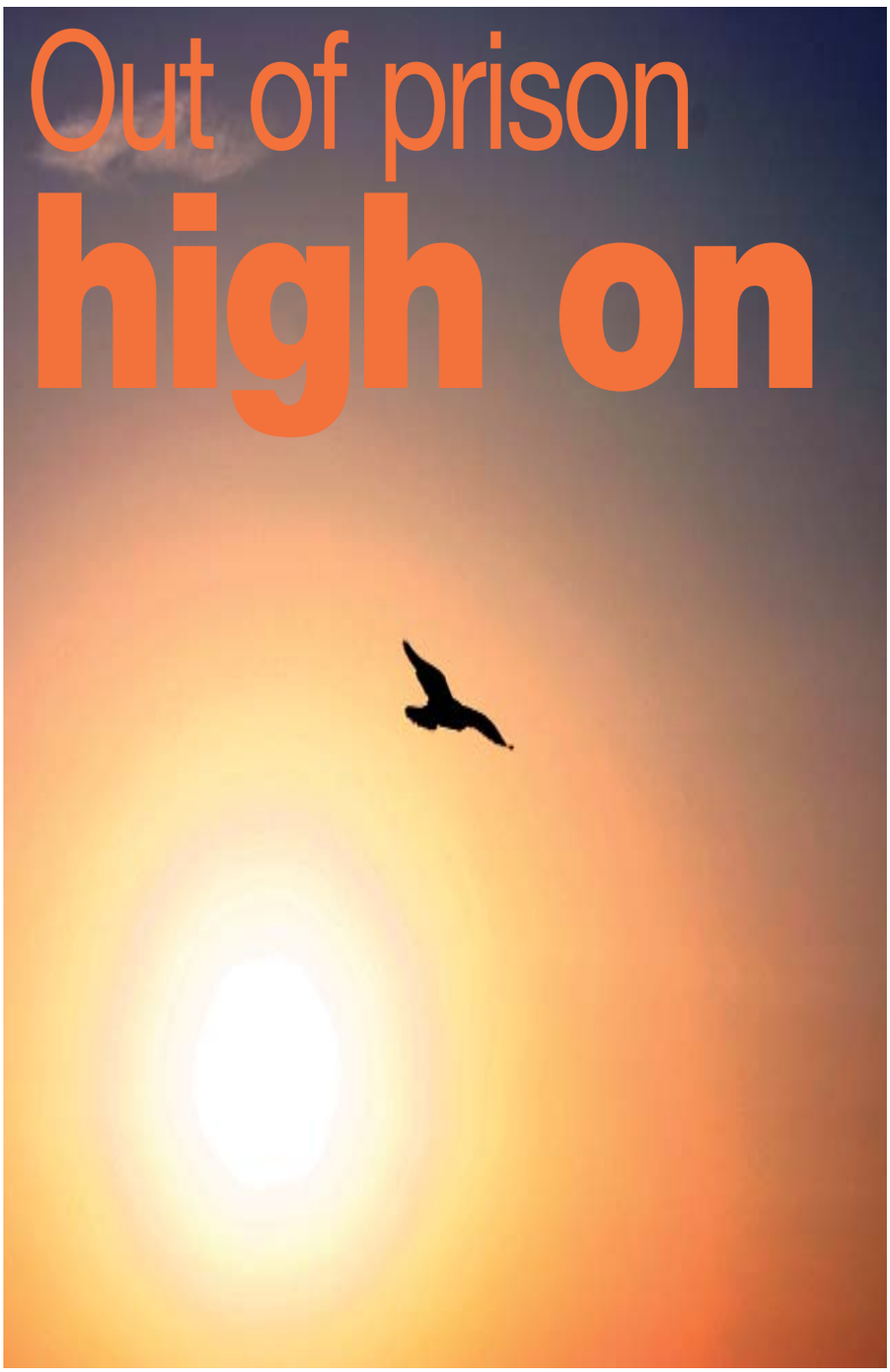
An increasing number of people are accessing treatment with problems arising from use of multiple drugs. This has led to definitions of recovery as abstinence from all traditionally defined drugs of misuse.

However, drug substitution can serve as an effective strategy through which some people ward off acute and post-acute withdrawal during their early search for recovery, *eg* the increased use of alcohol or cannabis during the first year of stopping using heroin.

If we say that these people are not in recovery or are not recovering, what do we say about those people that use prescription drugs such as benzodiazepines or the opiate substitute methadone to ease withdrawal?

And what about those people who continue to use the highly addictive drug nicotine? Is someone who has overcome heroin addiction, but still smoking cigarettes, in recovery?

Out of prison high on life



Prison drug workers and those supporting ex-prisoners in the community have a tough job. At RAPt's recent reunion for graduates of their 12-step prison drug treatment programmes, the gratitude shone through. Their personal stories show the scale of their journeys – and the difference drug workers have made to their lives.

'I'm in a place I thought I'd never be.'

Having chased highs since he was a child, Colin thought 'once an addict, always an addict' until he tried the RAPt programme just to get parole.

I believe I was born an addict. I was very unruly as a child. Anything that took me out of myself, made me happy, excited, scared – I just wanted more.

At night I would walk around by myself. I didn't want to go home, I needed something more. This was my behaviour pattern from an early age. When I came across drugs, I was ready for it. As a 12-year-old I would sit smoking a quarter ounce of weed. I thought it was normal.

I was first out of my peer group to do stuff. My biggest fear was that I didn't want anyone to know I was frightened. I wasn't particularly tough, I would come off worse in a fight. I was the first of my friends to drive. I would go to parties, roll spliffs, have drinks.

I progressed from party drugs. But the drugs weren't about having a good time, they were about changing the way I felt. I just wanted to be someone else.

My head wasn't a nice place to be, I was always beating myself up. When I came across crack and heroin it was ideal. All the stuff that came along with that – prison, being held up at knifepoint – I was prepared to go through that. I didn't want to be Colin, just sitting there.

I did drugs from age 12 to 35. I saw prison sentences as an occupational hazard. The only time I didn't take drugs was if I was in prison and couldn't get my hands on any. If they were there, I'd take them.

Once I was doing a slightly longer sentence – four and a half years – and I saw a poster for the RAPt programme. I was interested as I wanted parole, so I could start using again.

But on the programme something happened to me. Someone said 'you never have to use again'. I was frightened; I hadn't thought about that. I thought I'd become like the *Spitting Image* puppet of John Major – everything grey.

RAPt made me think. I'd thought only about myself. I used to ask mum why she was crying when I was the one locked up.

Having stuff of my own felt nice. I thought I'd try it, and thought 'what's the worst thing that could happen to me?'

Today I'm in a place I didn't think I'd ever be. I'm now working with people who are still using and trying to stop. It's difficult at times. I still felt at the beginning that I had more in common with the clients than the workers. Now I've got ten clients, and I'm trusted.

‘I believe I was born an addict. I was very unruly as a child. Anything that took me out of myself, made me happy, excited, scared – I just wanted more.’

‘I had to do my recovery where I’d done my using’

Cathy used RAPt’s Island Day Programme to give her the support to carry on her recovery outside prison.

I was thinking about where I come from and what was wrong with me. From a very young age I didn’t know how to ask for help. I hadn’t a clue how to live. I didn’t know how to communicate with other people. I thought if I stayed quiet and in the background at home, no-one would notice me.

Outside home, I was off and running. I started drinking by the time I was 11. I was brought up in the country and would drink half or a pint of homemade wine before school in the morning. It fortified me. From 11 to 14 I took speed, acid and cannabis. I thought it was normal.

When I was drinking I would reach my tolerance level so would have to have more and change substances. I kept on like that, taking speed and alcohol and running away. I thought I was wonderful, that one-one else knew how to live. I thought I was a rebel… but I was a rebel with nowhere to go.

I tried to manage my life. I thought if I had the right label, the rest would build around me. I used to live in university towns and go to lectures so they’d think I was a student. It took me another 20 years of using before I found recovery, including 17 years of methadone use. I tried many ways to stop the chaos.

I had a proper job with a pension and I thought that would do it. But I look back on those times and it’s so depressing. I went and detoxed as I’d got to the point where I couldn’t pretend to do life anymore. While I did my six-week detox I left my son at home on his own at 16 to do his GCSEs.

When I got home it turned out there was a 12-step programme on my doorstep in East London. Before that, the best they could offer was methadone. I had to do my recovery where I’d done my using.

What I got from RAPt was time, care and patience. When I first went there I was so angry, I kicked against those workers. When they had relaxation, I sat in the middle of the floor and cried, ‘why am I here in this horrible place?’

They cared for me, loved me – and gave me my step work to do. I survived.

When I graduated I spent a year volunteering at Tower Hamlets DAT. I tried to get aftercare on the agenda. I tried to do service user stuff, but I found it really disenchanting.

I did some training with RAPt – it was brilliant. When I started volunteering, I was in a place of hope. I started to take on board that I had hope inside. I started to take responsibility.

I did my step work but I felt education was for other people. Now I’ve started to see evidence of myself being successful in my own life. I’ve had a shift in belief.

Sharing the journey

RAPt graduates who ranged from 20 years to just 90 days ‘clean’ shared their life-changing experiences.

‘I walked into The Bridges [Rapt’s residential unit that helps ex-prisoners resettle in the community] with two pairs of jeans and two tops. Now I’ve got a job, money in my pocket and a life. The 12 steps is a simple programme for complicated people.’

‘Without RAPt I would never have heard of 12 steps or recovery. I went to RAPt so I could get a tag on my ankle and get out. But after six weeks it dawned on me I was in recovery and needed the rest of the 12 steps. I went to The Bridges and they taught me something I didn’t want to hear, which was the truth. Without RAPt I would have done what I’ve always done – my perception of reality was so far out the window. I’ve got a really good life now.’

‘I just came out of prison two days ago. It seemed safest to go back to what I knew – conning, lying. But I was tired, I was broken, I couldn’t do it anymore. I’ve learned to trust people. I can never put into words how grateful I am.’

‘Last week I was a year clean. If that counsellor hadn’t appeared at my door at Bullingdon I wouldn’t be here. When I was put in prison after a year on the run I was at rockbottom. I’m now a caretaker in a school. I’ve lots of responsibility. I actually feel human now. I’m eternally grateful to RAPt. You’ve given addicts a chance to live life and that’s worth more than anything.’

‘I’ll be 18 months clean next week and my life is now fantastic.’

‘I went onto RAPt because my friend was on there and I wanted to support her. Acceptance is my route to life. I’m due for my parole in January – if I don’t get it I’m not made to get it. My mum’s back in my life. There’s so much I’ve gained from this programme and so much I need to give back.’

‘I am a recovering alcohol addict. This programme has given me choices and peace. I was locked up but I gained freedom in my mind even though I was in prison. I’m eight years into my recovery. Without Geraldine [programme manager at HMP Send] and the programme, I would be dead today. I love having choices now.’

Let’s put our hands together for all the peer supporters throughout the country. Four of us from our landing got together and have been four years clean. RAPt was the gateway to my life. I live in Bournemouth now, five minutes from the beach.’

‘I’ve been in prison for five years. RAPt gave me a licence to save myself from myself.’

‘I was an addict for 26 years but I never had a problem… does that ring a bell? Even though it cost me my wife, children and business. RAPt gave me my life back and love – that’s what we all give each other at RAPt.’

‘I don’t need your approval anymore because I approve of myself. I was a serial relapser. One thing RAPt facilitates is education – believe in yourself, it can happen for you.’

‘Before I came to RAPt I was a walking corpse. I frightened people, I even frightened myself sometimes. I was sick of not doing anything with my life. Every time I shut a door it locked behind me.’

‘I went to RAPt on my knees. I came out of prison a year ago. Now I love life. Thanks to you all for giving us a chance.’

‘When I came into Send, I was pregnant. I have five children, but I couldn’t stop using till I found RAPt.’

‘I graduated yesterday so I’m still fresh. My drug use nearly got me thrown out of the country. The country where I was born didn’t want me no more. We didn’t become addicts in a day, so we’re not going to change in a day. But I’m now four years clean.’

‘I’ve been in prison most of my adult life. I came into Send and didn’t want to be touched by anyone. I’ve still got 16 months to go in prison but I’m free now.’

‘I got onto the programme because of a carat worker who doesn’t work there anymore. I would love to have seen her to thank her. I was four and a half stone lighter when I went into prison and I just didn’t know how to stop using. This programme saved my life.’ **DDN**

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- Evidenced excellent standard of written and spoken English
- Ability to communicate appropriately at all levels
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Telephone 07851 862 305 or write to RYP, The "Garage", Heatham House Youth Centre, Twickenham, Middx, TW1

Interviews to be held 23rd November 2007

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South Tyneside Drug Action Team
TACKLING DRUGS CHANGING LIVES

SOUTH TYNESIDE DRUG ACTION TEAM

TENDER FOR THE PROVISION OF A PRIMARY CARE-LED TIER 3 COMMUNITY PRESCRIBING AND TREATMENT SERVICE

South Tyneside Drug Action Team (DAT) invites expressions of interest from suitably experienced and qualified providers to tender for a Primary Care-led Tier 3 Community Prescribing and Treatment Service in the South Tyneside, Tyne and Wear area.

Although initially the service will be expected to provide treatment for drug users, it is anticipated that once funding is available a service will also be provided for problematic alcohol users

The service is commissioned by South Tyneside Drug Action Team and the successful tenderer will be expected to enter into a contract with South Tyneside Primary Care Trust (PCT).

Organisations with a track record of innovative and dynamic provision of services and a demonstrated capacity to respond to change are sought. The successful provider must be able to provide the following as essential service requirements:

Prescribing

- The service will provide all elements of Tier Three prescribing
- The service will be instrumental in developing additional, supplementary prescribing resources within the shared care arena

Harm Reduction

- The service will be underpinned by a harm minimisation philosophy. Harm reduction practices and approaches, such as BBV testing and vaccination as well as health advice will be provided as a priority
- Health care assessments will be provided by all staff and the service will improve the access to and take up of services by substance users to other relevant health services based within primary/secondary and acute care

Shared Care

- The service will develop, expand and support the number and range of GPs' involved in shared care arrangements in the area; ensure management of a Shared care Monitoring Group; develop and apply appropriate pathways and protocols with agencies; and manage the shared care contracts with GPs' in partnership with the PCT

Treatment effectiveness

- The service is required to develop, monitor and ensure effective pathways and joint-working arrangements with other Tier 2 and 3 agencies in the area
- The service will aim to be an integrated Health and Social care provision , and will include interventions around social inclusion factors that affect user retention and continuation in treatment in a holistic manner. The service will provide Triage, assessment, care coordination and a range of care planned treatment/support packages individually-tailored for user need, and will ensure compliance with Models of care and related guidance.
- The service will work in partnership with the relevant MH provider Trust to ensure that an effective protocol is developed in regard to users with a dual diagnosis.
- The service will aim to become the gateway for all detox and rehab resources for local users on behalf of statutory agencies, and to monitor usage and budget.

Access

- The service will improve the access and take up by substance users from all communities within South Tyneside by addressing access issues in relation to geographical location, under-represented groups and difficult to reach users by means of outreach and out of hours services where required etc. The service will provide flexible opening times, including at least one evening per week, and/or a weekend facility

It is anticipated that the service will be delivered as soon after the 1st April 2008 as is feasible for a period of 3 years with an option for a further extension of 1 year depending on future funding. Organisations should be aware that the Transfer of Undertakings (Protection of Employment) Regulations 1981 may apply.

For further details on the service please contact Mike Brown (DAT Commissioning Manager)
Tel: 0191 496 7963 Email: Mike.brown@stdrugactionteam.org

Requests for tender documentation and/or further details on contracting please contact:
Karen Moretta, Tyneside NHS Foundation Trust, Harton Lane, South Shields, Tyne & Wear, NE34 0PL
Tel: 0191 203 2959 Fax: 0191 202 4192 Email: karen.moretta@stft.nhs.uk

Requests for tender documentation should arrive no later than Monday 26th November 2007.

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Prison Drugs Service, HMP Dartmoor

Treatment Worker
(Programme Tutor)

Job Ref: 342-DA945-1007
Salary: Band 6 £23,458 - £31,779 pa

Working with people, working with change

We work in partnership with HM Prison Service to deliver high standard drug intervention and treatment programmes.

The Prison Partnership Twelve Step Programme (PPTSP) is an innovative accredited rehabilitation programme that is being delivered at HMP Dartmoor for offenders who are severely dependent and their substance use is linked to their criminal activity.

We require a skilled 12-step practitioner who thrives on teamwork to join a skilled team of practitioners to deliver an accredited 12-step programme within HMP Dartmoor. You will have the opportunity of facilitating a programme, which enables offenders to make informed choices regarding their substance use and associated behaviours.

You will need a good understanding of the Minnesota Method and have experience within the drugs field and/or a relevant professional qualification.

The interview process will consist of two parts - the prison will conduct a 'pass or fail' assessment centre, and the trust will then conduct a semi-formal interview to select the right candidate. The job is subject to satisfactory completion of programme facilitator training as delivered by the prison service.

We offer all staff personal development programmes, first rate supervision and training, a final salary pension scheme and occupational health services and are committed to equality of opportunity in employment.

For an informal discussion please contact Andrew Kirby on 01822 892106 or email: andrew.kirby@hmps.gsi.gov.uk

Apply online at: www.recruitment-awp.nhs.uk

Closing date: 21 November 2007

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(by Distance Learning)

A four year part-time degree-level course, open to applicants who are already working with clients with drug or alcohol problems. The programme will be delivered online, supported by intensive workshops every year in Leicester.

Module exemptions may apply to applicants who have relevant university qualifications or work experience.

Start date: **7th January 2008**

For further information please contact Dr A. Priest, 01604 736231, agp6@le.ac.uk or visit: www.le.ac.uk/lifelonglearning/counselling/courses

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The Causeway Retreat is the world's first private island retreat offering a unique and bespoke treatment programme for those who need help in managing their lifestyles. Based on a 400 acre estate which is situated 44 miles from central London, The Causeway Retreat continues to deliver groundbreaking treatment of drug and alcohol addiction to international clients.
Due to the success of our programmes we are looking to recruit the following:

Cognitive Behavioural Therapist

We are looking for a highly motivated, innovative and enthusiastic individual to join our friendly therapy team. CBT qualifications and experience are essential but we would also welcome additional skills in other brief therapies. The successful applicant will play a key role in developing services available to clients along with nursing, medical and therapy colleagues. He/she should be able to demonstrate an advanced level of expertise and the ability to exercise a high degree of professional autonomy.

Substance Misuse Nurses

We are seeking to recruit outstanding substance misuse nurses, with the motivation and skill base to help develop and deliver our programme and future programmes. Candidates must be dynamic, articulate and enthusiastic.

- Positions are full or part time
- The successful candidates can either be RMN or RGN but must be experienced in the addiction field
- A visit to the island is advisable
- Salary on application

If you are interested in this opportunity please e-mail a brief c.v. to info@thecausewayretreat.com or call us on 0207 100 7260

www.thecausewayretreat.com